Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EAST TEXAS MEDICAL CENTER
C/O FRANCIS, ORR & TOTUSEK, LLP
500 NORTH AKARD ST., SUITE 2550
DALLAS TX 75201

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-08-5580-01

MFDR Date Received
APRIL 25, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "ETMC's position is that the treatment provided at the Hospital was authorized by the carrier. The documentation included with this Medical Fee Dispute Resolution Request provider that the carrier authorized [injured workers] treatment."

Amount in Dispute: $16,365.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual has received the medical dispute filed by East Texas Medical Center for services rendered to [injured employee] for the 05/01/2007 date of service We have reviewed the bill and documentation attached to the medical dispute and our position remains unchanged. Our rational is as follows: A PLN 11 was filed 01/08/2007 disputing the occupational disease as it relates to the knee strain of 11/15/2006. Though the provider sought pre-authorization as required, the pre-authorization notice the provider received includes the following: 'Pre-authorization of this treatment/service request is based on determination that the treatment service is reasonable and necessary as outlined in the Teas Workers Compensation Act, Rules and Fee guidelines. Pre-authorization of this treatment is in now [sic] way an admission of liability or an agreement to pay if the case is adjudicated to be non-compensable and is not intended to interfere with the duty of the provider to adhere to any applicable practice standards.' The extent of the knee injury is disputed as non-compensable; therefore, Liberty Mutual does not believe that East Texas Medical Center is due any further reimbursement."

Response Submitted by: Liberty Mutual Insurance Co., 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2007	Outpatient Hospital Services	$16,365.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. Neither party submitted page 2 of the Explanation of Benefits; therefore the definition of the proprietary codes used by the respondent is unknown. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - (X553)
   - 150 – Payer deems the information submitted does not support this level of service.
   - (Z652)

Findings

1. Review of the documentation submitted with this medical dispute request documents the provider billed with the following diagnoses codes: 733.92 – Chondromalacia; 305.1 – Nondependent tobacco use disorder; and 727.83 Plica Syndrome. Chrondromalacia is defined as Abnormal softening or degeneration of cartilage of the joints, especially of the knee and Plica Syndrome is defined as pain, tenderness, swelling, and crepitus of the knee joint, sometimes with weakness or locking of the joint, caused by fibrosis and calcification of the synovial plicae. The PLN-11, filed by the respondent, disputes extent of injury for the diagnosis of intramensical degeneration of the posterior horns of both the medial and lateral meniscus as it does not relate to the compensable knee strain. The requestor did not bill with the disputed diagnosis; therefore, the disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The insurance carrier denied the disputed services with reason code 62 – "Payment denied/reduced for absence of, or exceeded, precertification/authorization. Review of the documentation submitted with this medical dispute request the requestor received preauthorization an arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal s [sic]." The above denial reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. The insurance carrier denied the disputed services with reason cove 150 – "Payer deems the information submitted does not support this level of service. Review of the submitted documentation finds that the requestor submitted medical records to support the services as billed. The carrier's denial code is not supported; therefore, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
4. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that amount sought in this dispute is fair and

reasonable.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 31, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.